

# Health Services Organization PMO 526

## **Health Policy, Legal, and Ethical Issues in Healthcare**

Paper # 5

### Purple People Protectors

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29 OCT 2002

Discuss the (1) administrative simplification, and (2) privacy and confidentiality provisions of the Health Insurance Portability and Accountability Act (HIPAA) and explain their impact upon healthcare providers, administrators and consumers. What challenges do you foresee these provisions imposing in terms of managing health systems?

With increasing health care costs and several areas that contribute to that increase as well as the increasing numbers of working Americans without health coverage, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 was signed into law. This law contains several aspects to address this main issue. They primarily include the enhancement of portability or protection of health insurance coverage if a job change or job loss occurs, increased access of long-term care coverage, reduction or elimination of healthcare fraud, encouraging the use of a medical savings account and most notably the administrative simplification of the health insurance. Within a managed care system, which handles an enormous amount of information for the individual patient and the collective system, the most significant and far reaching aspect of HIPAA is the administrative simplification of that information.

In order for the later provision of HIPAA to be accomplished at least three aspects will have to be addressed in detail. 1) Since individual patient information will need to be shared, which is the central theme of 'portability', standardized codes for the exchange of this information will need to be created. 2) The sharing of this confidential information will require the need for safeguards to maintain patient confidentiality. Therefore, security standards will have to be adopted. 3) To further aid in the simplification of the clinical data, unique identifiers will have to be created for the payer, patient, the employer and the provider. It is thought that implementation of these three standards will improve the efficiency and effectiveness of the nation's health care system by encouraging the exchange of electronic data in health care while at the same time maintaining patient confidentiality and privacy.

This paper examines the provisions of HIPAA that address issues surrounding administrative simplification of health care and the privacy and confidentiality provisions as well as their impact on the consumer, the health care administrator and the health care provider. Reinforcing the confidentiality and privacy of this patient information is an inseparable issue. We have explored both advantages and disadvantages of each.

We have explored the issues surrounding the need to ease the burden of disparate patient medical information. It has culminated in the creation of a network of shared but blinded medical information, which can be utilized in communications within our health care system.

The need to simplify appears to be very beneficial and but has the potential of evoking results that are quite the opposite of its' intention.

Compiling patient medical history into an electronic form with certainly ease the maintenance of that information. The entire patient record can be accessed much easier. This would include vital information that can be located in seconds such as pharmaceutical allergies, drug interactions or other contraindications for use of certain drugs or procedures in a particular patient. This has the potential of lifesavings. Preventative medicine scheduling dates such as vaccinations would be at the fingertips of the current provider. This alone has the potential of both a positive outcome of reducing the cost of treatment and follow-up care from a preventable disease as well as the patient wellness payoff. Furthermore, the creation of this electronic format is a timesaving venture, which will increase efficiency. Accessing to a patient's medical record with history will reduce the likelihood of repeated procedures that may not be needed. These two benefits translate to the savings of enormous health care dollars. Claims, payments and initial enrollments can be performed much easier also.

Sharing of this electronic information will result in multiple aspects of computing that have automated outcomes of many conveniences. Patients will be able to make and confirm appointments using web-based systems. Within TriCare, they are already consulting with physicians by electronic mail. These two benefits produce not only a more efficient system of health care delivery and management but they also encourage the fostering of the patient-provider relationship by allowing for more time contact time to the patient. Additionally, an electronic system of patient information would further benefit both patient and the system as a whole. It promotes an integrated system of physician-physician or provider-provider consultations and communications. The end result is both costs saving and potentially life-saving.

On the other hand, transforming a current patient record into binary format will require time and lots of it. The manpower for this conversion will be extensive based on sheer numbers. Hospitals, clinics and related organizations will need to create offices and staff focused on the separate task of complying with the rules and regulations of HIPPA alone. This quality alone is contrary to HIPPA aim of achieving "administrative simplification". Albeit a small probability, the record could contain initial and/or concurrent data entry errors, which may be perpetuated within the health care system. This would reduce time efficiency for corrections or possibly even result in detrimental patient outcomes. Furthermore, the e-record may not be all-inclusive. Patients either don't provide a total history, they are unwilling to release specific information or the provider is just unable to gather all the needed pieces of a patient medical history. The total history of a patient may be necessary information for the current benefit of the patient and provider but mainly got the treatment and prognosis of the patient

We are faced with the desire for increased quality of health care with the drastic need of lowering the cost. It stands to reason as we have been taught that the measure of health care quality is based on the outcome. Therefore, this electronic system of health care will require a very large sum of initial invested

money. The interface of computing domains will require one or more operating systems that are able to communicate within or among itself. For example as a D.O.S. system operates within a Microsoft Windows environment. The function of that operating system will need to be uniform and applicable for every provider, large or small. This alone will require personnel training. Again, this is contrary to the intended "administrative simplification". Also, since information technology moves at such a fast pace, how will the in-house systems of each individual provider/payer/employer keep up ? This issue doesn't take into account the need for pre-HIPPA information systems to be established to be used in communications. An agreement must be met that would call for a base start-up network. This inevitable will be time consuming and require large sums of money.

In the age of an increasing technology base, computerization and automation of information continues to be applied to areas that directly affect the consumer. The technology has proven to create opportunities and increase efficiency and productivity. On the other hand, we are forced to keep pace with the age. The utility of a locked office with a select few having the key to private and confidential patient information has now been superseded by the need to provide and re-define security for personal computer hard drives, web sites and networks that contain the same. Without doubt, this form of patient information can be used with tremendous benefit for the patient, provider and administrator. However, rather than a select few having admittance to privileged patient information, under the HIPPA provisions of a shared system, numerous network providers, administrators and managers will have to access to this information within a few key strokes. Even if the network is labeled as secure, this creates opportunity for computer hackers. These issues may very well have been expected since the provisions include "mandated security standards" and a "fraud and abuse control system" with large increases in fines. Control does not match prevention.

In order for HIPAA's legal standards to be met for privacy and confidentiality, the 2000 modifications require that all patient data be strictly de-identified. The potential impact of this restraint for health care providers to 'de-identification' data may be so extensive that it could limit research that utilizes consenting human subjects, epidemiology and disease surveillance. A fundamental need in research is to share data. This restriction may very well reduce or eliminate specific areas of research simply because sifting through the HIPPA Privacy Rules would be too extensive. Eventually, the impact of this will be felt in the consumer as a patient since less information has been gleaned from data that could be utilized for the benefit of the population as a whole. Furthermore for the researcher that chooses to carry-on despite the limitations, Internal Review Boards (IRBs) and Joint Commission Accreditation Hospital Organization (JCAHO) will certainly be faced with new issues of informed consent. Consent may well be redefined and take on different strata relative to the release of privileged information. This has the potential of redefining which

bits of personal data can be or will be disclosed within and outside the controlled network.

The Health Insurance Portability and Accountability Act was signed in 1996 and became effective as law in 1997. Since then, two revisions have occurred. The Department of Health and Human Service released the final medical-privacy rule in 2002, which should protect the privacy of medical information. The delay must have resulted for several reasons. First, Congress could not agree on medical-privacy legislation. Secondly, for the benefit of the health care system as a whole, the technical expertise, personnel, software and hardware will be extensive. This will require enormous capital. At least initially, this capital investment for start-up and compliance is again contrary to the intent of HIPPA and the rise in health care costs. Compliance will require monetary input from large-scale government all the way down to the small rural clinic. The taxpayer will ultimately be supplying the revenue for HIPPA and its' provisions but the hope is that the same will potentially benefit from its' outcome. Within the Department of Health and Human Services, the Centers for Medicare and Medicaid Services is charged with the task of implementing HIPPA. The outcome of which is perceived to be an increase in the quality of health care with a decrease in the cost.

Our health care system and government are both faced with several hurdles. Each of these hurdles has the potential of being the Achilles heel of HIPPA and our health care as a nation. The format of the data contained within the patients medical record will need to be met with a consensus and accepted within the entire network, software compatibility and currency will have to be maintained in the network as a whole, safeguarding of patient information must be vital, defense against system power outages, "glitches", viruses, and hacking must remain a priority and personnel training will be extensive initially but must remain current.

In conclusion, we consent that the potential benefits for the implementation and utilization of HIPAA are long-term. Lastly, the apprehension of government involvement in health care as well as technological advancements is well founded in historical facts from the perspective of TriCare, the benefits may far outweigh the initial disadvantages. The start-up costs will be extensive but the quality of care will be increased with a reduction in health care costs.